

**AOA ENT and Ophthalmology program closures as a model to highlight challenges of maintaining GME in high need areas.**

Kim Vo, MS<sup>1</sup>, Harris Ahmed, DO, MPH<sup>2</sup>, Wayne Robbins, DO<sup>3</sup>

1 – OMS-1, Western University College of Osteopathic Medicine, Pomona, CA.

2 – PGY- 1 Resident, Department of Ophthalmology, Loma Linda University, Loma Linda, CA.

3 – Associate Professor, Department of Otolaryngology, OhioHealth/Doctors Hospital, Columbus, OH.

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**Correspondence to:** Harris Ahmed  
11370 Anderson St #1800,  
Loma Linda, CA 92354  
(951)-858-3747  
[hahmed@llu.edu](mailto:hahmed@llu.edu)

**Abstract**

**Title:** AOA ENT and Ophthalmology program closures as a model to highlight challenges of maintaining GME in high need areas.

**Authors:** Kim Vo, MS<sup>1</sup>, Harris Ahmed, DO, MPH<sup>2</sup>, Wayne Robbins, DO<sup>3</sup>

**Introduction/Background:** Despite 90% of former American Osteopathic Association (AOA) residency programs transitioned to ACGME, surgical subspecialty programs such as ENT (47%) and ophthalmology struggled (61%) to gain accreditation; DOs actively participate in serving underserved communities and losing AOA surgical specialty programs may decrease access to surgical care in smaller communities.

**Objective:** To determine reasons and challenges behind former American Osteopathic Association (AOA) accredited surgical subspecialty programs' failure to transition to the Accreditation Council for Graduate Medical Education (ACGME), particularly surgical program in under resourced areas.

**Methods:** The directory of former programs was obtained from the American Osteopathic Colleges of Ophthalmology and Otolaryngology-Head and Neck Surgery (AOCOO-HNS). A secured survey was sent out to 16 eligible ENT and ophthalmology program directors. The survey contained both quantitative and qualitative aspects to help assess why these programs did not pursue or failed to receive ACGME accreditation.

**Results:** 12 of 16 eligible programs responded, comprising 6 ophthalmology and 6 ENT program directors. 83% of respondents did not pursue accreditation (6 ophthalmology and 4 ENT programs), and 17% were unsuccessful in achieving accreditation despite pursuing accreditation (2 ENT programs). Across 12 respondents, 7 (58%) cited lack of hospital/administrative support and 5 (42%) cited excessive costs and lack of faculty support as reasons for not pursuing or obtaining ACGME accreditation.

**Conclusion:** The survey results reflect financial issues associated with rural hospitals. Lack of hospital/administrative support and excessive costs to transition to the ACGME were key drivers in closures of AOA surgical specialty programs. In light of these results, we have 4 recommendations for program directors and Designated Institutional Officials: expand surgical subspecialties, identify of other surgical fields that faced similar barriers, address the lack of institutional commitment and excessive costs of maintaining subspecialty programs, and reconsider the approach to physician reimbursement.

## Introduction

Back in 2014, the American Osteopathic Association (AOA), the American Association of Colleges of Osteopathic Medicine (AACOM), and the Accreditation Council for Graduate Medical Education (ACGME) announced plans to institute a single accreditation system to oversee both allopathic and osteopathic residency programs under the ACGME by July 1, 2020. The premise of the single accreditation system was to promote and improve health and health delivery for the public by enhancing the quality and consistency of medical education, reducing costs, and increasing collaboration opportunities between allopathic and osteopathic physicians.<sup>1,2</sup>

When single accreditation began in 2014, it was recognized that many former AOA programs were in community settings and not academic health centers.<sup>3</sup> Faculty size and research development were not priorities for AOA programs, with the overall costs to maintain many AOA programs being less relative to costs associated with ACGME programs.<sup>4</sup> Meeting faculty, staff, resident size, infrastructure, and curriculum requirements of the ACGME were expected to be significant barriers for AOA programs making the transition,<sup>3</sup> yet by early 2020, nearly 90% of programs transitioned successfully.<sup>5</sup> For surgical programs, however, the transition was far more difficult. Only 47% of the Ophthalmology programs, or 7 out of 15, and 61% of the otolaryngology (ENT) programs, or 13 out of 21 programs, transitioned.<sup>6</sup> Without ACGME accreditation, these 16 AOA programs will be shut down, potentially reducing the number of Doctor of Osteopathic Medicine (DO) surgical subspecialists in the workforce.<sup>7,8</sup>

A previous study by Fordyce et al. established that DO primary care physicians are more likely to serve in smaller communities and rural areas than their allopathic counterparts.<sup>9</sup> Recently, studies by Griffith et al. and Ahmed et al. have shown that DO ENTs and ophthalmologists also follow similar practice patterns.<sup>7,8</sup> The active participation of DOs in rural health care addresses and mitigates existing physician shortages in underserved areas across the United States. Physicians practicing in high-needs areas are critical, as a significant aspect of our national physician shortage is related to regional distribution issues.<sup>10</sup>

The loss of AOA ophthalmology and ENT programs will decrease opportunities for DOs to pursue these surgical subspecialties. A smaller pool of DO surgical subspecialists may ultimately affect smaller, rural, and underserved communities, decreasing access to surgical specialist care. It is unclear why surgical specialty programs such as ENT and ophthalmology struggled to obtain ACGME accreditation. Since DO specialists are more likely to work in smaller underserved and rural areas, it is pertinent to understand the reasons behind the failure of former AOA surgical programs' transition under the ACGME system, as these programs' closures may impact health care delivery in areas of high need. Uncovering these reasons may also help

us understand the more significant challenges we face in establishing and maintaining graduate medical education programs in under-resourced communities.

This study aims to uncover why a significant percentage of former AOA surgical specialty programs such as ENT and ophthalmology did not transition to the ACGME under the single accreditation system, from the perspective of the individual program directors of programs that did not achieve accreditation.

## Methods

A directory of former Ophthalmology and Otolaryngology (ENT) residency programs was obtained from the American Osteopathic Colleges of Ophthalmology and Otolaryngology-Head and Neck Surgery (AOCOO-HNS). This directory represented AOA ENT and ophthalmology programs that existed before the single accreditation process began in 2014. A secured survey to program directors of former AOA ENT and ophthalmology programs that did not achieve ACGME accreditation. This helped reveal challenges faced by these programs, many of which were in cities with less than 50,000. This survey examined why accreditation was not pursued or obtained using two questions, each with response options generated through personal communication with AOA ENT and ophthalmology program directors. Another response option with a comment box was provided for both questions.

1. If you did not pursue ACGME accreditation, why did your program not pursue ACGME accreditation? (Choose one or more of the following)

2. If you did apply for ACGME accreditation, why did your program not attain ACGME accreditation? (Choose one or more of the following)

## Results

Out of the sixteen programs that were issued surveys, twelve respondents, comprising six ophthalmology and six ENT program directors, completed the survey. Ten (83%) of the respondents did not pursue ACGME accreditation, and two (17%) of the respondents pursued ACGME accreditation but were unsuccessful in achieving accreditation. The most common reason behind the programs' inability to pursue or achieve accreditation was the lack of hospital/administrative support (7 of 12, 58%). Other frequently selected reasons included excessive costs and lack of faculty support (5 of 12, 42%). "Other" was chosen by 50% of respondents, citing common reasons associated with the cost-benefit of accreditation. ACGME research and academic requirements (4 of 12, 33%), logistical/facility requirements (3 of 12, 25%), excessive paperwork (3 of 12, 25%), and surgical case volume requirement (2 of 12, 17%) were also cited as reasons for not pursuing ACGME accreditation. (Table 1).

Given the relatively smaller sample size in this survey, data from both Ophthalmology and ENT respondents' "other" reasons in their non-pursuit for ACGME accreditation were aggregated. The Ophthalmology program respondents who chose "other" cited limited office space and independent third-party consultant recommendation not to pursue accreditation from a cost benefit perspective. ENT programs' responses varied. These included a program in which the hospital system merged all residency programs within a nearby university, vs. another program closed its ENT residency to expand other residency programs. One ENT program

director stated that their sponsoring institution did not want to commit the time and money involved to achieve ACGME accreditation and felt that had their hospital supported the ENT residency that they would have successfully attained ACGME accreditation.

Table 1: Overall reasons for not pursuing or obtaining ACGME accreditation (Combined ENT and Ophthalmology Program Director Responses)

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### **Discussion**

Based on our survey results, the most common issues faced by former AOA surgical subspecialty programs that failed to receive ACGME accreditation were related to finances, logistics, and administration rather than clinical and surgical volumes. Lack of quality in programs such as those with smaller surgical and clinical case volumes may be logical reasons to close former programs. However, it seems that surgical and clinical volume was not a common issue for most former AOA ENT and Ophthalmology programs as only 3 of the 12 programs cited surgical or clinical volume as part of their decision not to pursue ACGME accreditation. In light of these results, we have recommendations that should interest program directors and Designated Institutional Officials who faced similar issues in other medical specialties, hospital Chief Medical Officers that supervise program transitions, residents interested in how transitions towards ACGME accreditation could impact their future medical education, and health policy experts examining physician access in high need areas.

**Recommendation #1:** Expand Teaching Health Center Graduate Medical Education (THCGME). Currently, THCGME has successfully established GME in high-need areas with high primary care physician retention rates. However, no such program exists for surgical programs despite increasing needs in surgical subspecialties in the rural workforce.

**Recommendation #2:** Study other former AOA surgical subspecialty programs. Our findings were specific to ENT and Ophthalmology programs, yet while only 50% of neurosurgery programs transitioned to ACGME accreditation, and 90% of urology AOA programs are now ACGME accredited.<sup>4</sup> Systematic inquiry is necessary to determine if other affected surgical fields faced similar barriers to transitioning to single accreditation. It may be beneficial to study former AOA urology programs to determine which characteristics of the urology programs contributed to their high transition rate to the ACGME. Of the ten urology programs that transitioned successfully, four were in cities with a population of less than 50,000.

**Recommendation #3:** Address the lack of institutional commitment and high cost to maintaining subspecialty programs in high-need areas. To a certain extent, we propose reexamining specific ACGME requirements to accommodate former AOA residency programs to increase surgical specialty care access in high-need areas. In particular, requirements surrounding academic output (research projects and publications), faculty size, and distance between training sites may be reexamined to reduce costs and increase support for these programs.

**Recommendation #4:** The Centers for Medicare & Medicaid Services (CMS) to reconsider its physician reimbursement approach. Currently, CMS periodically enacts alterations to their fee schedule that involves the reallocation of funds between fields. In the last several years, including the proposed fee schedule for 2021, CMS has enacted and proposed cuts to reimbursement for all surgical subspecialties.<sup>12</sup> While increasing support from primary care

specialties is essential and critical to public health, it should not come at the expense of surgical specialties. Such decline in reimbursements also contributed to ENT and ophthalmology program closures. In our discussions with program directors, they often mentioned that the cost of enhancing programs to meet ACGME requirements was too high for institutions to justify the investment, especially when considering declining reimbursement from public insurance entities such as CMS. Multiple institutions determined that it was more financially feasible to pursue their primary care program transitions.

### **Conclusion**

When the AOA initially debated the single accreditation system, a major concern was regarding rural programs' ability to achieve ACGME accreditation. Nearly thirty percent of the 132 AOA training programs in rural locations did not achieve ACGME accreditation, the majority of which were primary care programs but also included surgical subspecialty fields.<sup>1</sup> Typically, the lack of access to physician care in rural communities is due to rural hospitals experiencing difficulty recruiting physicians and remaining financially viable.<sup>13</sup> Our survey results reflect our rural hospitals' financial issues. Respondents highlighted the lack of logistical and administrative support and ongoing costs to maintain AOA surgical specialty programs as significant reasons for not pursuing/receiving ACGME accreditation. We have provided four recommendations to understand further and address this rural workforce issue.

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